EXCLUSION OF PROCEDURES TREATMENTS OR THERAPIES
ACUPUNCTURIST - LOUISIANA

In consideration of the premium paid, it is agreed that the **PROFESSIONAL LIABILITY COVERAGE PART**, **Section V. Exclusions**, is amended to add the following:

This Coverage Part provides no coverage including **claim expenses**, based on, arising out of, or related to any of **your** acts, errors or omissions involving the procedures, treatments or therapies as designated below:

- Acupuncture as anesthesia during surgical procedures
- Chiropractic manipulation and/or adjustment
- Use of Cold Laser
- Colonic irrigations
- Dehydration of hemorrhoids
- Direct Moxibustion
- Fever therapy
- Gemstone therapy
- Use of Reusable needles
- Use of Toftness device
- Treatment of animals
- Treatment or reduction of a fracture
- X-ray, microwave and radium
- Maibotsushin, Okibari or any prolonged insertion of needles (ear tacs or seeds are acceptable)
- Obstetrics including the care and treatment of women during pregnancy and childbirth, and infants less than fourteen days old
- Fertility, contraception, or infertility.
- Any service, treatment, advice or instruction for the purpose of skin or appearance enhancement, personal grooming, cosmetic procedures and salon or spa services including botox or its homeopathic equivalent or any fluid injection
- Treatment of cancer, epilepsy, or acquired immune deficiency syndrome, except that treatment is not excluded if such treatment is solely to alleviate pain and during the entire period of treatment, the patient is under the care of a licensed physician for the condition or disease and **you** do not interfere with the course of treatment recommended by such patient's treating physician.

All other terms and conditions of the Policy remain unchanged.

This endorsement, which forms a part of and is for attachment to the Policy issued by the designated Insurers, takes effect on the effective date of said Policy at the hour stated in said Policy and expires concurrently with said Policy unless another effective date is shown below.

By Authorized Representative_____
(No signature is required if issued with the Policy or if it is effective on the Policy Effective Date)